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**Frequently Asked Questions-FAQs on the Proposed**
**AREA HEALTH SERVICES AND FACILITIES MASTER PLAN AND HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM**

1. **Why is there an initiative for a new Health Facilities Construction Priority System (HFCPS)?**
   Response: FY 2002 conference language asked IHS, in consultation with the Tribes and the Administration to review and make recommendations for a revised methodology that is more flexible and responsive.
2. **What are the costs and the benefits of an Area Health Services and Facilities Master Plan (AHSFMP)?**
   Response: Two AHSFMPs have been completed and each cost approximately $400,000. The benefits are significant because master plans may be used for determining and addressing the unmet health services need of the AI/AN people. In addition, the AHSFMPs will provide a basis for assessing and prioritizing health care facilities space needs.
3. **How will Urban and tribally owned facilities be considered by the HFCPS?**
   Response: Urban Health Programs should be included in the Area Health Services and Facilities Master Plans but IHS has no authorization to construct urban facilities. It is anticipated that if additional funds become available for urban Indian facilities, they will be funded through the urban line item. Every other facility, identified as part of a primary service area in an area master plan, including tribally owned facilities, are eligible for consideration under the HFCPS.
4. **Why does the revised HFCPS methodology result in a list that is set up for five years?**
   Response- The HFCPS is designed to provide a list of high priority projects to Congress for possible funding. This list is commonly referred to as the Priority List. Projects placed on the Priority List provided to congress remain on that list until they are funded or removed by other Congressional action even if it takes longer than 5 years. Only projects that have approved Program Justification Documents are placed on the Final Priority List, and these projects will not be re-prioritized. However, it is expected that every 5 years IHS will review all other facilities to determine those that should receive further evaluation for possible placement on the Priority List. During this process, all projects are given a general priority rating that may change from cycle to cycle. Re-evaluating these facilities every five years will ensure that the most current information is used in prioritizing projects submitted to Congress and will allow primary service areas to develop new health delivery innovations and other planning changes and allow newly recognized Tribes to participate in the HFCPS. The number of projects on Priority list submitted to Congress for possible funding is variable because IHS will place on that list only as many projects as it anticipates to be funded during the 5-year cycle. The five years is considered a minimum planning, design, and construction period for the projects on the final list.
5. **How do self-determination Tribes find the resources to develop a master plan?**
   Response: Each Area must develop a funding strategy which includes all Tribes. Cooperation and collaboration with the Area and compacted Tribes should be pursued to obtain costs effective master plans.(Refer to Question 15)

6. **What happened to the proposed concept for an Area Level Priority List for renovation work where there is no additional staffing involved?**
   Response: This feature is planned to be handled under separate proposals through the Department and Congressional budget process. A white paper has been developed on this issue. The proposal has merit and will be considered in detail as the HFCPS develops.
7. **What documents will be used for and when is the proposed HFCPS going to be available for tribal consultation?**
   Response: IHS is developing guidelines based on the Final FAAB Workgroup Report. These guidelines will be distributed for Tribal consultation as soon as comments from the IHS and the FAAB are incorporated into the documents.
8. **Is the replacement costs adjusted by area or location?**
   Response: The HFCPS will use the IHS Facilities Budget Estimating System (FBES) to determine replacement costs. The FBES utilizes adjustment factors for different geographical areas.
9. **What score would a Primary Service Area (PSA) with no existing facility receive?**
   Response: The priority score for a PSA with no existing facility would be evaluated in the same way as all other facilities, except that the Facility Deficiency Factor used in the formula would be the maximum possible. Other factors, such as Health Indicators, Access to Care, etc. would be variable based on the situation.
10. **Since self determination tribes that own facilities are not required to maintain a Facility Deficiency System (FDS) backlog, what options do they have to indicate necessary facility repair backlogs?**
    Response: All Tribes are eligible to participate in the FDS database and IHS encourages the self determination Tribes to maintain active participation in the FDS system. The initial Facility Condition Survey can be accomplished with M&I funding and the maintenance and updates to the system are routine and conform to recommended Facility Management practices. IHS will maintain the Tribal data provided the data is furnished in compatible electronic language. The other option is for the Tribe to furnish a written report of the facility deficiencies for the comparable FDS categories using a comparable construction estimating system.
11. **What happens to the reliability of an Adjusted Clinical Group (ACG) score for a primary service area with an undersized health facility resulting in a majority of the user population obtaining health services elsewhere?**
    Response: The IHS data for ambulatory and inpatient services codes the community of all patients, and all communities are assigned to a primary service area. This means that anomalies such as that referenced in the example can be accounted for through referral or contract care data.
12. **What is the detailed definition of the "nearest outpatient facility or emergency room?"**
    Response: The nearest travel time in minutes to a health care facility offering outpatient services or having a level 1, 2, or 3 emergency room.
13. **Who determines and verifies the percentage of the population that does not have access to public transportation?**
    Response: It is the HSFMP that will provide public transportation data to determine the "access to public transportation score." IHS area and headquarters staff will review and determine validity of the data provided in the master plan.
14. **What happens to unfunded projects that are on the present Priority List?**
    Response: Projects that have approved planning documents (Program Justification Documents) will be retained in priority order. When the HFCPS is fully developed,

it is not clear how projects that do not have approved planning documents will be addressed by the Congress.

15. **Does an IHS Area with many self-determination Tribes, need a HSFMP similar to the master plan developed for the Phoenix Area.**
    Response: The services plan may not be all that complex and may be readily documented by representatives of the Tribal health boards with some input from the Area Health planning team. This effort would save consultant resources for the services portion of the Master Plan. The information gathered for each Tribe needs to be included in the Area Master Plan and data entered into the database, possibly with consultant assistance, for use in compiling the HFCPS.
16. **Is it possible for a Tribe that has more than enough facilities space overall to score a large HSPBA (Space calculated from an Health System Planning Program (HSP) without deviations) if considering a chosen set of communities needing a chosen set of limited services?** Response: Once the PSA is defined in the Services Master Plan the user population and the required space would not be able to be manipulated for an increase in score in the manner posed in the question.
17. **Is IHS imposing unnecessary informational or financial burdens, such as FDS data development with IHS compatible estimates, that are not residual or regulatory mandated, on Tribes with non-IHS facilities.**
    Response: There is no intention to impose an unnecessary burden on the self-determination Tribes but the Priority System must have comparable data to produce replicable scores for all PSAs nationwide. As stated in response number 10 above, IHS will offer technical assistance to achieve compatibility with the FDS system and preserve fairness among all Tribes and PSAs.
18. **If a Tribe intends to develop or contract for the development of their own HSFMP , under Title I or V, what criteria can be used as a minimum guide for deliverables and reporting format for the data?**
    Response: An actual master plan for a Tribe or PSA does not exist at present but the format would follow closely the criteria of the Area-wide master plan. Also, the data gathered needs to be formatted and submitted in accordance with the HSFMP database.
19. **How do Tribes and Primary Service Areas that fall below the HSP minimum workloads, (Primary Care Provider Visits (PCPVs) under 4400 and user population under 1,320) determine their supportable space and staff for their ambulatory care facilities?**
    Response: Small Ambulatory Care Facility Criteria has been developed for these facilities and is being incorporated along with the HSP to develop supportable space and staff for smaller ambulatory facilities.
20. **Why is the HSP, without deviations, being utilized to determine the supportable space in lieu of the formula recommended in the Needs Assessment Workgroup ($0.8m^2$ x user population + $200m^2$)?**
    Response: The formula method indicates large discrepancies as the user population and the facility gets larger. There is another factor that is independent of size and that is the specific demographics of the PSA . A white paper has been developed indicating some of the size differences of IHS facilities between the formula calculations and the sizes determined by HSP and the Health Facilities Planning Manual.